

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-015632

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 157 Primary Registration District No. 3028 Registrar's No. 66

FILED APR 26 1962

1. FILED DATE a. COUNTY <u>Jasper</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jasper</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Carthage</u>		c. CITY OR TOWN <u>Sarcoxie</u>	
Length of stay in lb <u>1 Month</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>McCune Brooks Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>301 S. 7th St.</u>	
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Homer</u> Middle <u>Cecil</u> Last <u>Brown</u>		4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2-17-1890</u>
9. AGE (last birthday) <u>72</u>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shell Pine Line</u>	
11a. BIRTHPLACE (City and state or country) <u>Sarcoxie, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James Brown</u>		13b. MOTHER'S MAIDEN NAME <u>Lou Ellars</u>	
14. NAME OF HUSBAND OR WIFE <u>Merle Brown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>[REDACTED]</u>	
17. INFORMANT <u>Mrs. Homer C. Brown</u>		Address <u>Sarcoxie</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of lung.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>arterio-sclerosis generalized</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	Month, Day, Year _____		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>Carthage Mo</u>	
20g. COUNTY <u>Sarcoxie</u>		20h. STATE <u>Mo.</u>	
21. I attended the deceased from <u>4-6-62</u> to <u>4-13-62</u> and last saw her alive on <u>4-13-62</u> Death occurred at <u>8:10 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>George H. Wood M.D.</u>		22b. ADDRESS <u>Carthage Mo</u>	
22c. DATE SIGNED <u>4/16/62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4-15-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sarcoxie Cemetery</u>	
23d. LOCATION City, town, or county <u>Sarcoxie, Mo.</u>			
24. FUNERAL DIRECTOR <u>Ulmer-Moss Funeral Home, Sarcoxie, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>4-16-62</u>	
26. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300
Rev. 4/59

1 0497
2 0490
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4 0
5 1
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12 2-0
13 3-0

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Melvin Garrett

Licensed Embalmer No. 5121

P. O. Address Carthage, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.